DOCUMENT RESUME

ED 177 442 CG 013 879

TITLE	The Use of Family Therapy in Drug Abuse Treatment: A National Survey. Services Research Report.
INSTITUTION	George Washington Univ. Medical Center, Washington, D.C.
SPONS AGENCY	National Inst. on Drug Abuse (DHEW/PHS), Rockville, Md. Div. of Resource Development.
REPORT NO	ADM-78-622
PUB DATE	78
GRANT	NIDA-H81-DA-01478
NOTE	16p.
AVAILABLE FROM	Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402 (017-024-00704-8)
EDRS PRICE	MF01/PC01 Plus Postage.
DESCRIPTORS	*Agencies; *Drug Abuse; *Family Counseling; Questionnaires; *Rehabilitation Counseling; *Therapists; *Therapy

ABSTRACT

A survey sought to determine the nature and extent of family therapy practiced in treatment and rehabilitation agencies serving drug abuse clients. Questionnaire responses to a three-phase study were on a voluntary basis. Phase I, with a 60% response rate, gathered information on the number of drug abuse treatment agencies providing family services. Phase II obtained indepth information on types of facilities that treat families, roles and techniques of family therapy, demographic characteristics of the treatment populations, and staff profiles. The Phase II response rate was 36%. Phase III evaluated 36 sites at 8 different locations in the country through questionnaires distributed to administrators, family therapists, agency directors and students, if available. Primary issues raised in Phase III were that, although therapists treated complete families, they received census credit for only one family member, and that there is a need for comprehensive training programs for family drug therapists. (Author/BMW)

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National Institute on Drug Abuse

SERVICES RESEARCH REPORT

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The Use of Family Therapy in Drug Abuse Treatment:

A National Survey

CG013879

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Public Health Service
Alcohol, Drug Abuse, and Mental Health Administration

The Services Research Reports and Monograph Series are issued by the Services Research Branch, Division of Resource Development, National Institute on Drug Abuse (NIDA). Their primary purpose is to provide reports to the drug abuse treatment community on the service delivery and policy oriented findings from Branch-sponsored studies. These will include state-of-the-art studies, innovative service delivery models for different client populations, innovative treatment management and financing techniques, and treatment outcome studies.

The findings presented in this report were developed under NIDA grant no. H81 DA 01478 to the Center for Family Research, George Washington University Medical Center, Washington, D.C.

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DHEW Publication No. (ADM)78-622
Printed 1977 Reprinted 1978

For sale by the Superintendent of Documents, U.S. Government Printing Office
Washington, D.C. 20402
Stock No. 017-024-00704-8

CONTENTS

	Page
ACKNOWLEDGMENTS	2
SUMMARY	3
METHODOLOGY	4
Limitations of the Study	5
FINDINGS - PHASE I	6
FINDINGS - PHASE II	6
Client Characteristics	7
Role of Family Therapy in the Agency	7
Training	9
Therapist Characteristics	9
FINDINGS - PHASE III	11

LIST OF TABLES

Table		Page
1	Distribution of Modalities of Phase I Agencies	5
2	Primary Drug of Abuse in Rank Order	7
3	Staffing Patterns	8
4	Timing, Frequency, Length, and Limit of Family Therapy Treatment	10
5	Role of Family Therapy in Agency	11
6	Family Therapists Demographics	12
7	Techniques Used in Family Therapy	13

ACKNOWLEDGMENTS

In June of 1975, the Services Research Branch of the Division of Resource Development, National Institute on Drug Abuse, and the Center for Family Research of George Washington University Medical Center in Washington, D. C. jointly sponsored a two-day symposium on family therapy in drug treatment agencies. These two days of discussions reinforced the Institute's decision to conduct a national survey of programs that provide treatment services to drug abusers, to determine the nature and extent of family therapy services currently being provided.

The survey was designed and conducted by Sandra B. Coleman, Ph.D., with assistance from Ms. Doreene Kaplan. Donald Davis, M.D., of the Center for Family Research served as Principal Investigator. This report of the survey results was produced by the staff of NIDA's Services Research Branch.

SUMMARY

This survey set out to determine the nature and extent of family therapy practiced in treatment and rehabilitation agencies serving drug abuse clients. Since the provision of services to families of drug abuse clients varied widely among all agencies, the quality and real nature of the family therapy services provided could not be assessed from this type of survey. It must also be remembered that, due to the relatively low response rate, responding agencies cannot be viewed as truly representative of the drug abuse treatment field. Also, many of those agencies that did respond treated populations other than drug abusing clients, as well, and thus cannot be assumed to be an accurate representation of the way in which drug abuse clients alone are treated.

However, this survey does provide an indication of the extent of family therapy services and a fairly clear description of many of the family therapy-related activities prevalent in various treatment settings. For instance, a finding that is consistent throughout is that there are relationships between the proportion of heroin abuse clients in an agency and both the degree to which use is made of family therapy as a major treatment technique and the extent to which family therapists are trained. In sum, clients abusing opiates get less family therapy and are more likely seen by less formally trained family therapists/counselors. At the same time, programs serving opiate abusers primarily express a greater interest in increased involvement in family therapy counseling.

A great deal of variation regarding the use of family therapy was found among treatment settings. Outpatient clinics or drug-free therapeutic communities were most apt to treat the client and the entire family, while methadone maintenance clinics were most likely to provide couple therapy for the addict-client and his or her spouse. In viewing these findings, one must keep in mind that clients differed by age, primary drug of abuse, and availability of family members among the treatment settings, and that the treatment settings themselves varied in terms of resources and staff composition.

It is interesting to note that the two primary issues raised by the sample of 36 agencies site-visited were: (1) that they did not receive census credit for more than the one identified patient in family therapy; and (2) that a comprehensive training program for family therapists in the addiction field should be introduced.

The majority of evidence points to the relatively low priority given to family therapy by most agencies. Only 8 percent of respondents made provision of family therapy mandatory. An average of 15 percent of all the responding agencies' clients were in family therapy at the time of the survey. Only nine agencies called family therapy the primary form of treatment. Where family therapy was provided, however, families generally attended weekly sessions and tended to complete the sequence of treatments. Role playing and family tasks were the primary treatment techniques used. This suggests that agencies serving drug abusers use procedures and techniques similar to those employed with other client populations.

THE USE OF FAMILY THERAPY IN DRUG ABUSE TREATMENT: A NATIONAL SURVEY

Michele M. Basen, M.P.A., Editor

Family therapy is an approach to psychosocial counseling that attempts to treat a client within the context of his or her family relationships. The interaction of the family group is considered to exert an influence on the client's deviant behavior, and to provide a mechanism for resolving difficulties and supporting the client's rehabilitation. In that context, family members--parents, spouses, children, other influential relatives--may be involved in either individual and group counseling activities on the client's behalf, with or without the client present.

There is increasing belief among clinicians and researchers involved in substance abuse treatment that the client's family can play a significant role in the treatment and rehabilitation process. A review of the recent literature both in family therapy and in substance abuse treatment reveals a growing number of clinical and descriptive articles on providing family therapy to drug abusers. This interest in the field led the National Institute on Drug Abuse (NIDA) to sponsor a two-day symposium on family therapy and drug treatment in June 1975. Discussions at this symposium pointed up the need to gain clear information on the state-of-the-art of family therapy in drug treatment.

Therefore, in 1976 NIDA sponsored a survey of over 3,000 drug abuse treatment agencies to explore the nature and scope of family therapy practices. Specifically, information was sought regarding the number and types of drug abuse treatment agencies currently treating clients in the context of their family environment, the types of family services provided in differing drug abuse treatment settings, and the staffing patterns employed. Information was also sought on the qualifications of staff providing family services, the proportionate number of family therapists to other direct service staff, and the availability of training in family therapy techniques. Background information was gathered on the characteristics of these agencies attempting family therapy, such as funding, admission procedures, physical and geographic characteristics, and the demographic characteristics of the treatment populations. A separate profile of family therapists working in the drug abuse field was also developed.

METHODOLOGY

A three-phase study design was employed to examine the issues identified. Phase I was intended to gather information on the number of drug abuse treatment agencies providing family services. A one-page questionnaire--the Facility Information Form, consisting of closed-ended questions--was sent to the 3,335 agencies identified as providing drug abuse treatment services by the 1976 National Drug Abuse Treatment Utilization Survey (NDATUS). These treatment units were located in drug treatment agencies, community mental health centers, private and State psychiatric hospitals, outpatient clinics, and "other" modalities, such as drop-in centers (see table 1). Usable questionnaires were returned from 1,986 of the agencies, a response rate of 60 percent. Of these, 1,846 agencies or 93 percent of the respondents reported providing some services to

TABLE 1

DISTRIBUTION OF MODALITIES OF PHASE I AGENCIES

MODALITY	FREQUENCY	PERCENTAGE*
Therapeutic Communities	491	24.7
Methadone Maintenance Units	370	18.6
Outpatient Drug-free Units	444	22.4
Detoxification Units	108	5.4
Community Mental Health Centers	457	23.0
State Psychiatric Hospitals	35	1.8
Private Psychiatric Hospitals	35	1.8
Other (Storefront, Drop-in)	650	32.7

*Percentages add to greater than 100 because some responding agencies reported themselves as offering two or more modalities of drug abuse treatment.

to the families of clients.

The purpose of Phase II was to obtain indepth information regarding the types of facilities that treat families, such as the facilities' staffing patterns, the drugs abused by the facilities' patient populations, the roles and techniques of family therapy in the differing agencies, the demographic characteristics of the treatment populations, and the profiles of staff working with families.

Two instruments were designed for Phase II: The Family Therapy Questionnaire, consisting of 260 items; and the Therapist Information Fact Sheet, consisting of 40 items. Both made substantial use of Likert scaling. The two scales were mailed to 1,372 agencies (of the total 1,846) that had returned Phase I questionnaires prior to a predetermined cutoff date. Phase I questionnaires returned after the cutoff date were included in the Phase I analyses, but not in Phase II. Usable questionnaires from Phase II were returned from 500 agencies, a response rate of 36 percent of the Phase II sample.

Phase III of the study consisted of site visits to a selection of 36 treatment facilities from eight different regions of the country. The site-visited agencies were identified and selected from those reporting family services in Phase I and from reports by project consultants.

A set of structured interview forms was designed as the major instrument for Phase III. Standard questions were addressed to administrators, family therapists, agency directors, and students, if available. A three-page evaluation form was used to standardize information collected from each visit.

Limitations of the Study

Study findings must be regarded with caution due to the relatively low response rates obtained. The response rate for the first questionnaire (Phase I) was 60 percent. There is no information on the use or nonuse of family therapy from 40 percent of the sample. Usable Phase II questionnaires were returned from only 500 agencies, representing only 15 percent of the original Phase I population of agencies. It is likely that those 500 self-selected agencies represented those with a particular interest and investment in family therapy.

Results from neither Phase I nor Phase II can be viewed as truly representative of the NDATUS agency population to which questionnaires were originally mailed. Moreover, the agencies from which responses were received are not representative of agencies treating drug abuse clients only. A good number of

the agencies treated predominantly nondrug-abusing populations. Also, the position of the person filling out the questionnaire at the treatment facility varied, thereby allowing for differing understandings and concerns about the study.

FINDINGS - PHASE I

From a total sample of 1,986 agencies responding to the Facilities Information Form, 1,846 (93 percent) reported that they provided some type of services to clients' families, while 140 reported that they did not provide any family services. One can conclude from this phase, then, that a minimum of 1,846 of the NDATUS file of 3,335 agencies, or 55.4 percent, considered themselves as providing some type of family services.

The type of services offered to families varied, but in general clinics were apt to report themselves as offering multiple forms of family therapy. Agencies were asked to indicate the type of family therapy practiced from among the following choice of services: group therapy for parents; couple therapy for the addict-clients' parents; couple therapy for addict-client and his or her spouse/cohabitor; family therapy including the addict-client; family therapy without the addict-client; and individual therapy for family members. The most frequently cited type of therapy is family therapy including the addict-client; this was reported by 1,375 agencies, or 74.5 percent of the sample. The second most frequent type of family therapy was couple therapy with the addict-client and his or her spouse. This treatment mode accounted for 1,238 agencies, or 67.1 percent of the sample.

An attempt was made to compare type of treatment setting and type of family therapy provided. In drug-free therapeutic communities, private psychiatric hospitals, outpatient clinics, and "other type" modalities (usually storefront or drop-in centers), the most frequent type of family service reported was family therapy including the addict-client. Methadone maintenance clinics most frequently offered couple therapy for the addict-client and his or her spouse, followed closely in frequency of reports by family therapy including the addict-client. Detoxification units and State hospitals do not show clear differences among the several types of family therapy, although family therapy including the addict-client was among the types most often reported. By contrast, community mental health centers were most apt to report use of individual therapy for family members as their approach to working with families. For community mental health centers, therapy including the addict-client was the second most frequently reported type of family therapy.

For all treatment settings, the family therapy least likely to be used was couple therapy for addict-client's parents. This had the lowest frequency of reports for detoxification units, community mental health centers, and therapeutic communities.

Of those Phase I agencies providing some type of family services and treating drug and alcohol problems only (N=1,048), 71.5 percent provided family therapy including the addict-client; 62.2 percent provided couple therapy for addict-client and his or her spouse; 61.4 percent provided individual therapy for family members; 44.4 percent provided family therapy without the addict-client; 35.7 percent provided group therapy for addict-clients' parents; 31.9 percent provided couple therapy for parents.

Of 1,931 Phase I responses to the question of perceived importance of family therapy, 1,473 agencies (76.3 percent) responded "highly important"; 419 agencies (21 percent) responded "moderately important"; 37 agencies (1.9 percent) responded "of minimal importance"; and 2 agencies (0.1 percent) responded "not necessary at all." Only 30 percent of the Phase I sample elected to respond to questions related to interest in, and need for, providing family services. Methadone maintenance clinics, when compared with other modalities, expressed the most interest.

FINDINGS - PHASE II

Analyses were completed on 500 agency responses to the two Phase II questionnaires. Of the 500 agencies, 130 were multimodality programs. The remaining 70 agencies offered a single type of treatment; their distribution was:

Modality	N
Outpatient	94
Methadone Maintenance	38
Community Mental Health Center	76
Drug-free Therapeutic Community	67
Other (usually drop-in, storefront)	95
	370.

The average number of clients in any agency's monthly census was 156 clients (based on 449 respondents). Community mental health centers reported the largest number of clients; drug-free therapeutic communities reported the least. In all modalities, male clients outnumbered female clients by a ratio of 3:2. The average age of clients in treatment was 25 years. The oldest clients tended to be in drug-free therapeutic communities.

Client Characteristics

As shown in table 2, heroin was found to be the most frequent primary drug of abuse (27.7 percent), closely followed by alcohol (21.4 percent) and marihuana (19.5 percent) (N=470). As expected, methadone maintenance clinics treated the highest proportion of heroin abusers; community mental health centers treated the lowest proportion of heroin abusers and the highest proportion of alcoholics; outpatient centers and the "other" type modalities treated the highest proportion of marihuana users.

TABLE 2

PRIMARY DRUG OF ABUSE IN RANK ORDER (N=449)

RANK	DRUG	MEAN PERCENTAGE OF ALL CLIENTS
1	Heroin	27.7
2	Alcohol	21.4
3	Marihuana	19.5
4	Barbiturates	8.9
5	Amphetamines	6.9
6	Other Sedatives	5.8
7	Hallucinogens	4.9
8	Other Opiates	3.9
9	Inhalants	2.6
10	Cocaine	1.7

In addition to requesting demographic information for treatment populations as a whole, the Phase II instruments requested information to differentiate between clients in family therapy and those in the general treatment population. Those in family therapy were reported to have somewhat higher incomes and higher educational levels. The two treatment groups differed considerably on the basis of race, with white clients comprising the major portion of those receiving family therapy. As would be expected, data also suggested that those in family therapy were more apt to be married than divorced, separated, widowed, or cohabiting.

Role of Family Therapy in the Agency

The Phase II instruments requested data on the number of full-time and part-time staff, and the number of staff doing family therapy. Table 3 presents findings on staffing patterns.

Data were also gathered on the persons participating in family therapy. As suggested above, the identified patient was reported as included in family therapy a great part of the time, and the mother or spouse was also often included. The father was seen somewhat less regularly. Other family members attend sessions with less frequency; in only rare instances are children, siblings, and extended family members present.

Significant differences were obtained both by agency setting and by type of drug abused. For instance, spouses were seen most often in methadone maintenance clinics;

TABLE 3

STAFFING PATTERNS (N=496)

POSITION	MEAN NUMBER PER PROGRAM
Professional Therapists	
Full-time	2.5
Part-time	1.3
Doing Family Therapy	2.5
Paraprofessionals	
Full-time	4.7
Part-time	1.3
Doing Family Therapy	2.6
Physicians	
Full-time	0.1
Part-time	0.6
Doing Family Therapy	0.1
Nurses	
Full-time	1.3
Part-time	0.5
Doing Family Therapy	0.3
Administrative Staff	
Full-time	2.1
Part-time	0.4
Doing Family Therapy	0.2
Research Staff	
Full-time	0.3
Part-time	0.2
Doing Family Therapy	0.0
Educational Staff	
Full-time	0.6
Part-time	0.5
Doing Family Therapy	0.1
Other Staff	
Full-time	2.2
Part-time	1.3
Doing Family Therapy	0.3

parents, siblings, and children were more apt to be participants in family therapy in clinics where opiate abusers made up less than 25 percent of the treatment population. In general, the larger the percentage of opiate abusing clients, the lower the number of family members involved in treatment. Whether this difference is due to age of client, availability of family members, type of facility, type of drug problem, etc. cannot be determined at this time.

Agencies reported that sessions with family members most often occurred on a weekly basis, although some agencies reported biweekly sessions. Agencies rarely reported any effort to limit the length of therapy.

As shown in table 4, the data suggests that most families complete treatment; however, methadone maintenance clinics were most apt to report that scheduled family therapy terminated abruptly (after or even before the first session).

It seems clear that, for almost two-thirds of the 474 agencies responding, family therapy was seen as ancillary to other treatment forms. Nine agencies (1.9 percent) suggested that it was their primary form of treatment. Thus, despite the fact that a variety of members attend family sessions with some regularity, the role of family therapy in most agencies is not primary.

As can be seen in table 5, in 75 percent of the responding agencies (N=484), the family therapist or counselor who sees family members reportedly either established independent policies regarding treatment delivery or did so in conjunction with approval from others. The counselor providing family treatment was identified as the primary therapist for the identified patient in 77 percent of the responding agencies.

Training

The issue of training in family therapy techniques and the extent to which an agency was able to adequately supervise and further train its staff in family therapy was a major focus of the survey. It was found that 48.3 percent of the agencies provided some training in family therapy to both professionals and paraprofessionals. Training was typically provided within the treatment setting. Agencies providing services primarily to opiate abusers reported less training and less supervision available.

Overall, the average amount of time devoted to training staff to work with families was 13.9 percent of the total training time available. Twenty-seven percent of the 450 responding agencies reported providing funds for training in family counseling. Where differences existed, there again was an inverse relationship between percentage of opiate abuse clients in an agency and degree to which budget support existed for family therapy training in those agencies.

Therapist Characteristics

To explore therapist characteristics, the 1,117 therapist information fact sheets received from the 500 Phase II agencies were analyzed. There were slightly more male therapists (57.5 percent) working with families than females (42.5 percent) and white therapists outnumbered other racial/ethnic groups in all cases (86.6 percent). More than half of the family therapists were married; another 22 percent were previously married, but were now either separated, divorced, widowed, or cohabiting. Only 9.4 percent of the therapists reported being former addicts, themselves. With regard to education, 60 percent of the therapists reported having graduate degrees and 84.4 percent reported being at least college graduates. Clinics treating both drug abuse and non-drug abuse clients--e.g., community mental health centers and "other" clinics--reported staff with more education than agencies treating drug abusers exclusively--e.g., therapeutic communities and methadone maintenance clinics. In addition to the high level of education already acquired, 35.7 percent of the therapists reported they were still attending school.

Nearly two-thirds (63.6 percent) of the family therapist population indicated they had some specific training in family therapy. The average number of years a therapist had worked in his or her present position was two years. Demographic data on the 1,117 family therapists who responded to these questionnaires are shown in table 6.

TABLE 4

TIMING, FREQUENCY, LENGTH, AND LIMIT
OF FAMILY THERAPY TREATMENT

FAMILY THERAPY TREATMENT PARAMETERS	FREQUENCY OF RESPONSE				
	Never	Rarely	Sometimes	Often	Always
Time of Introduction					
At initial entry	9.4	19.3	32.2	31.8	7.4
After "black out"*	62.3	14.1	12.1	9.0	2.5
Several months into treatment	14.6	28.5	37.0	16.6	3.3
At re-entry	34.6	21.2	22.1	16.8	5.3
Frequency of Sessions					
Once per week	8.9	12.0	16.7	47.8	14.6
Every two weeks	16.1	19.0	46.2	17.3	1.4
Once per month	23.9	34.0	27.4	11.7	2.9
Other Interval	75.5	6.6	8.9	5.4	3.7
Optimal Length					
1-6 weeks	42.3	21.7	18.8	14.6	2.7
6-12 weeks	40.4	15.2	22.3	19.8	2.3
3-6 months	40.9	18.8	22.9	14.8	2.5
6-12 months	44.6	24.2	16.3	11.9	3.1
Termination					
0 sessions	32.4	43.9	18.1	5.5	0.2
1 session	14.3	47.1	32.1	6.3	0.2
Ends during treatment	7.1	11.8	54.6	25.0	1.5
Completion of treatment	4.8	8.4	23.1	47.7	16.0

*"Black out" refers to a period of time in which the client is not in contact with family members.

TABLE 5

ROLE OF FAMILY THERAPY IN AGENCY

VARIABLE	PERCENTAGE IN TOTAL SAMPLE
Structure of Family Therapy	
Separate department with a director	4.5
Separate department without a director	7.0
Subset of another department	22.5
Not part of formal structure	61.0
Primary form of treatment	1.9
Policy Decisions Regarding Family Therapy	
Set independently by family therapists	36.8
Set by family therapists with approval of others	38.6
Family therapists make recommendations - Decisions made by others	10.3
Decisions made conjointly	7.4
Family therapists have little or no part	2.3
Family Therapist is Primary Therapist for Identified Patient	
Yes	77.1
Sometimes	9.2
Family Therapists Make Decisions Affecting Family	
Yes	67.6
Sometimes	4.1
Family Therapist Controls Medication	
Yes	10.3
Sometimes	0.5

Some light was shed on the extent to which family therapists actually work with families by exploring the role of family therapy vis-a-vis nonfamily therapy. Therapists reported an average monthly caseload of 20.3 nonfamily cases, compared with 8.4 family therapy cases. Similarly, the weekly average of therapy time devoted to nonfamily cases was 17.8 hours, compared with 6.7 hours for family therapy cases. The largest family therapy caseloads were found in agencies serving the smallest proportion of opiate abusers in their patient populations. This information was consistent for both caseload numbers and hours per week devoted to family therapy. Further evidence that family work generally is not given priority was clear from the fact that only 4.5 percent of the therapists worked exclusively with families, while 95.5 percent reported having other responsibilities in addition to family therapy.

Table 7 demonstrates the various family therapy techniques practiced in agencies. Family tasks ranked first in the degree of use and role-playing ranked second.

PHASE III - FINDINGS

Although agency directors at the 36 sites visited by project team members stated that they viewed family therapy as "vital," funds allocated to family therapy represented a small portion of their total treatment dollars. The 36 agencies reported the major problem in the decision to allocate funds to family therapy was the fact that they did not receive census credit for family members participating in treatments, but only for the one identified patient in family therapy.

TABLE 6

FAMILY THERAPIST DEMOGRAPHICS

ITEM	PERCENTAGE IN TOTAL POPULATION
Sex	
Female	42.5
Male	57.5
Race	
Black	9.4
White	86.6
Other	4.0
Marital Status	
Never Married	20.6
Married	56.2
Separated	4.6
Divorced	11.9
Living Together	5.5
Widowed	0.5
Former Addiction	9.4
Educational Level	
High School	5.7
Two Years College	8.4
Nursing School	1.5
BA/BS Degree	25.8
Masters Level	49.7
Doctorate Level	8.9
Currently in Educational Program	35.7
Specific Training in Family Therapy	63.6

N=1,117

TABLE 7

TECHNIQUES USED IN FAMILY THERAPY

TECHNIQUE	DEGREE USED IN TOTAL POPULATION				
	Always	Often	Sometimes	Rarely	Never
Role Playing	2.5	28.5	45.4	16.0	7.7
Family Tasks	13.0	43.2	30.7	7.4	5.6
Psychodrama	0.6	6.7	21.0	28.9	42.7
Sculpting	0.6	6.3	16.4	22.0	54.8
Nonverbal	4.9	13.8	20.4	10.8	50.1